907 KAR 3:210 and E
Incorporation by Reference

"MAP-10, Physician Recommendations for Waiver Services”
(July 2008 edition)

"MAP-24C, Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program”
(July 2008 edition)

"MAP-26, Program Application Kentucky Medicaid Program Acquired Brain Injury (ABI) Waiver Services Program"
(July 2008 edition)

"MAP-045, Incident Report"
(July 2008 edition)

"MAP-95, Request for Equipment Form”
(June 2008 edition)

"MAP-109, Plan of Care/Prior Authorization for Waiver Services"
(July 2008 edition)

"MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form"
(July 2008 edition)

"MAP-351, Medicaid Waiver Assessment"
(July 2008 edition)

"MAP-2000, Initiation/Termination of Consumer Directed Option (CDO)"
(July 2008 edition)

"Mayo-Portland Adaptability Inventory-4"
(March 2003 edition)

"Person Centered Planning: Guiding Principles"
(March 2005 edition)

"Family Guide to The Rancho Levels of Cognitive Functioning”
(August 2006 edition)

Filed: _____

Map 10
(Rev 7/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
WAIVER SERVICES
PHYSICIAN'S RECOMMENDATION

PLEASE RETURN THE FORM TO THE REQUESTED LISTED BELOW.

_____
(Requestor's Name)

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

PHYSICIAN'S RECOMMENDATION

I recommend Waiver Services for:

_____ _____
(Member) **(Medicaid Member Id #)**

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

DIAGNOSIS (ES): _____
_____

Recommended Waiver Program:

- ☐ HCBW (ARNP, PA or Physician signature)
- ☐ ABI Waiver – Services to adults with acquired brain injury (21–65 yrs) with a potential for rehabilitation and retraining (Physician signature)
- ☐ ABI Long Term Care Waiver – Services to adults (18 yrs and older) with acquired brain injury who have reached a plateau in their rehabilitation level and require maintenance services. (Physician signature)
- ☐ SCL Waiver (SCL QMRP or Physician signature)
- ☐ Michelle P. Waiver – Non-residential Services to children and adults **with mental retardation or developmental disabilities. (ARNP, QMRP, PA or Physician signature)**

I certify that if Waiver Services were not available, institutional placement in a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded/Developmental Disabled shall be appropriate for this member in the near future.

_____ _____
(Authorized Signature) **(UPIN#:)**

_____
(Address)

_____ **KY**_____ _____
(City) **(Zip)** **(Phone)**

_____
(Date)

Kentucky
UNBRIDLED SPIRIT

Map – 24C
(Rev. 07/2008)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program

TO: **(1)** _____ County Office
Department for Community Based Services

(2) Quality Improvement Organization (QIO)

(3) Department for Mental Health, Developmental Disabilities and Addiction Services for SCL Waiver **or** Department for Medicaid Services/Acquired Brain Injury Branch for ABI Waiver or the ABI/LTC Waiver

FROM: **(4)** _____
Case Management Agency/Support Broker

DATE: **(5)** _____

(A) MEDICAID WAIVER PROGRAM

(Check program)

☐ ABI ☐ SCL
☐ ABI/LTC ☐ MP

(Check type of action)

☐ Admission ☐ Discharge
☐ Temporary Discharge ☐ Readmit from Temporary Discharge
☐ Change in Case Management Company ☐ Change in Primary provider
☐ Change of client address ☐ Facility / Hospital Admission/Discharge

Date of above action: _____

(B) CLIENT INFORMATION:

_____ _____ ____ _____
(Last Name) (First Name) (MI) (Social Security Number)

_____
(Address)

_____ KY _____ _____
(City) (Zip) (Phone number)

(C) CASE MANAGEMENT AGENCY/SUPPORT BROKER INFORMATION

_____ _____
(Name) (Provider #)

_____
(Address)

_____ KY _____ _____
(City) (Zip) (Phone number)

Map – 24C
(Rev. 07/2008)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program

Re: CLIENT NAME: _____ SS#: _____

(D) PRIMARY PROVIDER INFORMATION

(1) Primary Provider

_____ _____
(Provider Name) (Provider #)

_____
(Address)

_____ KY _____ _____
(City) (Zip) (Phone)

Monthly Cost: _____

(E) FACILITY/HOSPITAL INFORMATION

Admission Date: _____ Discharge Date: _____

(1) Facility/Hospital Name: _____

_____
(Address)

_____ KY _____ _____
(City) (Zip) (Phone)

(2) Reason for Admission

_____
_____
_____

(3) Discharge Outcome

_____
_____
_____

(F) WAIVER PROGRAM DISCHARGE

Voluntary: ☐ **Involuntary:** ☐

(1) Reason for Program Discharge

_____
_____
_____

**IF DISCHARGE IS VOLUNTARY, SUBMISSION OF DOCUMENTATION SIGNED BY THE GUARDIAN/LEGAL REPRESENTATIVE IS REQUIRED CONFIRMING INTENT TO DISCONTINUE SERVICES.

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

For placement on the Acquired Brain Injury or Acquired Brain Injury Long Term Care Medicaid Waiver waiting list, an individual must first submit this application and a signed MAP10 - Physician Recommendation Form. A copy of the Physician Recommendation form is enclosed for your use.

Please mail the completed application and the signed Physician's Certification form to:

Acquired Brain Injury Services Branch
275 East Main Street 6W-B
Frankfort, Kentucky 40621

An individual will be placed in the waiting list in the order in which the application and the Physician Recommendation form are received in the office of the Acquired Brain Injury Services Branch. If the individual meets one of the following emergency criteria, he/she will be determined to have emergency status. Funding available will be allocated to individuals having emergency status prior to allocating funding to individuals having non-emergency status. The emergency status criteria are:

1. The individual is currently demonstrating behavior related to his acquired brain injury that places himself/herself, the caregiver, or others at risk of significant harm; OR

2. The individual is demonstrating behavior **related to his acquired brain injury** which has resulted in arrest OR

3. For the ABI/LTC only, the ABI Rehab Waiver is no longer able to meet the needs of the individual.

***If the individual is applying for emergency status, a written statement by a physician or other qualified mental health professional shall be required to support the validation of risk of significant harm to a recipient or caregiver. Written documentation by law enforcement or court personnel shall be required to support the validation of a history of arrest.**

Qualified Mental Health Professional:

- **Physician**
- **Psychiatrist**
- **Psychologist or Psychological Associate**
- **RN with a masters degree in psychiatric nursing and 2 years professional experience with mentally ill persons or a Licensed Registered Nurse who has 3 years experience in psychiatric nursing and is currently employed by a hospital or company engaged in the provision of mental health services.**
- **LCSW**
- **Marriage and family therapist with 3 years of clinical experience in psychiatric mental health practice and currently employed by a hospital or company engaged in the provision of mental health services.**
- **Professional counselor with 3 years clinical experience in psychiatric mental health practice and currently employed by a hospital or company engaged in the provision of mental health services.**

Map -26
(Rev. 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

For program use only
Date Received: _____
Time Received: _____
Notice Sent: _____

Please provide the following personal information for the individual seeking services through the Medicaid waiver.

Check the Program the individual is applying for: ABI: ☐ ABI/Long Term Care: ☐

A. Client Information

_____ _____ ____ _____
(Last Name) (First Name) (MI) (Social Security Number)

_____
(Address)

_____ KY _____ _____
(City) (Zip) (Phone number)

_____ _____
(Date of Birth) (Date of Brain Injury)

Cause of Injury: _____

B. Guardian Information (if Applicable)

_____ _____
(Name) (Relationship to individual)

_____
(Address)

_____ _____ _____
(City) (county) (Phone)

C. Caregiver Information (if Applicable)

_____ _____
(Name) (Relationship to individual)

_____
(Address)

_____ _____ _____
(City) (county) (Phone)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PROGRAM APPLICATION
KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY (ABI) WAIVER SERVICES PROGRAM

Please answer the following questions.

1. Has the individual identified a case management provider to assist in securing and coordinating services once you are admitted to the ABI waiver program? ☐ Yes ☐ No

2. If yes, what is the name of the organization that will provide case management?

3. Does the individual currently demonstrate behavior that places himself/herself or a caregiver at risk of significant harm? ☐ Yes ☐ No

4. Is Emergency Status consideration requested for this individual? ☐ Yes ☐ No

5. **If yes**, please attach a statement from a physician or other qualified mental health professional describing the nature and extent of the risk of harm involved.

6. Is the individual demonstrating behavior **related to his acquired brain injury** which has resulted in arrest? ☐ Yes ☐ No

7. **If yes**, please attach an arrest record or a statement from law enforcement or the court indicating what type of offense(s) for which the individual has been arrested.

_____ _____
Signature of guardian Signature of applicant

_____ _____
Name of person completing application Relationship to applicant

_____
Telephone # of person completing application

Questions about individual referrals or the Acquired Brain Injury Medicaid Waiver or the Long Term Care Waiver program may be directed to the Brain Injury Services Branch by calling, toll free, (866) 878-2626. Thank you.

INCIDENT REPORT

To document issues that impact the health, safety, welfare, or lifestyle choices of individuals

IDENTIFYING INFORMATION: ☐ ABI ☐ ABI-LT ☐ DCBS ☐ Michelle P ☐ SCL ☐ SGF

Class ☐ I ☐ II ☐ III

Medicaid Member ID #: Name: Adjudicated? ☐ Yes ☐ No

DOB: Reporting Agency: Provider Number:

Reporting Person: Title: Phone:

Case Mgmnt Provider: Case Mgr Name:

INCIDENT INFORMATION:

Date of ☐ Incident ☐ Discovery: / / Time: am/pm

LOCATION OF INCIDENT		REPORTED TO	NOTIFICATIONS (Case Mgr./Sup. Broker: Class I and II–24 hrs/Class III-8 hrs. Guardian: Class I –as directed / Class II and III– 24 hrs. Class III: DCBS–Immediate (if applicable) and DMR: 8 hrs.)		FINAL REPORT (Class II – 10 Days Class III – 7 days)
☐ Residence	☐ Job Site				
☐ Day Program	☐ Home Visit				
☐ Community	☐ Transportation Broker	Case Mgr./Support Broker	Date: / /	Time: a/p	Date: / /
☐ Respite	☐	Regulating Agency	Date: / /	Time: a/p	Date: / /
Address:		Guardian/Individual	Date: / /	Time: a/p	Date: / /
		DCBS	Date: / /	Time: a/p	Date: / /
Phone:			Date: / /	Time: a/p	Date: / /

INCIDENT DETAILS:

What happened immediately before the incident?

What happened during the incident?

What happened immediately following the incident?

If the incident happened again, what would you do differently?

Signature of person witnessing the incident Title: Date:

INCIDENT CODES (select all that apply)

☐ A – Suspected Abuse	☐ H – Suicide Attempt	☐ P – Emergency Room Visit
☐ B – Suspected Neglect	☐ I – Severe Behavior Outburst	☐ Q – Hospitalization, Medical
☐ C – Suspected Exploitation	☐ J – Property Damage	☐ R – Hospitalization, Psychiatric
☐ D – Death of an Individual	☐ K – Self Abuse	☐ S – Medication Error
☐ E – Emergency Chemical Restraint	☐ L – Individual Aggressed to Staff	☐ T – Serious Injury
☐ F – Emergency Physical Restraint	☐ M – Peer on Peer Aggression	☐ U – Police Involvement
☐ G – Threatened Suicide	☐ N – Negative Media Attention	☐ V – CMHC Crisis Referral
Other	☐ O - Elopement	☐ W – Urgent Treatment Center Visit

STATE USE - Follow-up Indicator: ☐ Cabinet Staff Follow-up ☐ Desk Level Investigation ☐ On-Site Investigation

Kentucky UNBRIDLED SPIRIT

INCIDENT FOLLOW-UP

(Add additional pages if necessary)

Social Security Number: _____ Name: _____ Incident Date:

Diagnoses: Axis I: _____

Axis II: _____

Axis III: _____

Recent Medical Concerns:

Does the individual have: Yes No

Rights Restrictions ☐ ☐ Please list rights restrictions: _____

Behavior Support Plan ☐ ☐

Crisis Plan ☐ ☐

Why did this incident occur? (analysis of cause – not restatement of the information on page 1):

Individual Issues	System Issues
How many times has this kind of incident happened with this individual in the past three months?	How many times has this kind of incident happened in your agency in the past three months
What did you do to keep the person safe and well?	What system(s) or policy(ies) failed to prevent this incident from occurring or contributed to the incident occurring?
What changes will occur in the in the individual's life to prevent the incident from recurring and how will they be documented?	
When will the individual's team meet to consider these changes?	Why did this system or policy not work as was intended?
How should these changes be implemented?	
When should these changes be implemented?	How will the system or policy be changed to prevent recurrence?
Who should ensure these changes are implemented and followed?	
What concerns did the individual express when you talked with them about this incident?	When will the system or policy be changed?
How does the individual report they are doing today?	Who will monitor the system changes to ensure they are implemented and followed?
Signatures:	
Program Director / Supervisor	Signature:
Case Manager/Support Broker	Executive Director/MRDD Director

MAP 95
(Rev. 6/07)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

REQUEST FOR EQUIPMENT FORM

RECIPIENTS NAME: _____ DOB: _____

MAID or MEMBER #: _____ DX: _____

Estimated Time Needed: Months _____ Indefinitely _____ Permanently _____
One Time Only_____

Procedure Code: _____ Date: _____

ITEM	ESTIMATE 1	ESTIMATE 2	ESTIMATE 3	TOTAL COST (includes shipping)

AGENCY NAME: _____

PROVIDER NUMBER: _____

CASE MANAGER/SUPPORT BROKER: _____

TELEPHONE NUMBER: _____

AUTHORIZED DMS SIGNAUTRE: _____

DATE APPROVED: _____

Kentucky
UNBRIDLED SPIRIT

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

☐ **Initial**
☐ **30 Day**
☐ **Annual**
☐ **Modification**

Residential Status
☐ **In Home**
☐ **Family Home Provider**
☐ **Adult Foster Care Provider**
☐ **Staffed Residence**
☐ **Group Home**

Type of Waiver Program
☐ **SCL**
☐ **HCB**
☐ **MP**
☐ **ABI**
☐ **ABI/LTC**
☐ **Traditional**
☐ **CDO**
☐ **Blended (CDO/Traditional)**

1. MEMBER NAME: _____ _____ ___ Sex: ☐ MALE ☐ FEMALE
Last First MI

2. MEDICAID MEMBER ID #: _____ 3. DOB: _____

4. ADDRESS: _____
Street

_____ ____ _____ _____ 5. HOME PHONE:_____
City State Zip County

6. CASE MANAGEMENT/SUPPORT BROKER AGENCY (CDO):_____ _____
Phone

7. GUARDIAN NAME: _____ _____ _____
Relationship: Phone

8. POWER OF ATTORNEY: _____ _____ _____
Relationship: Phone

9. REPRESENTATIVE NAME (CDO ONLY): _____: _____
Relationship

10. ADDRESS: _____
Street

_____ ____ _____ _____ 11. PHONE:_____
City State Zip County

12. LEVEL OF CARE (LOC) CERTIFICATION NUMBER: _____

13. LOC CERTIFICATION DATES: FROM: _____ TO: _____

14. PRIMARY CAREGIVER: _____ _____
Relationship

15. ADDRESS: _____
Street

_____ ____ _____ _____ 16. PHONE:_____
City State Zip County

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ **Medicaid Member ID#**:_____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ **Medicaid Member ID#:** _____ **Date Services Start:** _____

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
						Total Cost per Month $

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column D x 4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month $

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ **Medicaid Member ID #:** _____

List each provider/employee name, address and telephone number:

Provider/Employee Name	Provider Number	Address	Phone Number

Clinical Summary:

Map 109
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ Medicaid Member ID #: _____

Emergency Back-up Plan (CDO only)

_____

_____

_____

_____

_____

_____

_____

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

_____ _____
Member/Guardian Signature Date

_____ _____
Case Manager/Support Broker Signature Date

_____ _____
Representative Signature (CDO) Date

Plan of Care/Support Spending Plan ☐ **Approved** ☐ **Denied**

_____ _____
QIO Signature/Title **Date**

Map -350
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____
Signature Date

II. HOME AND COMMUNITY BASED (HCBS) WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, SUPPORTS FOR COMMUNITY LIVING (SCL) WAIVER, MICHELLE P (MP) WAIVER, MODEL II WAIVER, AQUIRED BRAIN INJURY (ABI) WAIVER, AQUIRED BRAIN INJURY LONG TERM CARE (ABI/LTC) WAIVER.

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS Waiver program as an alternative to NF placement is requested ☐; is not requested ☐.

_____ _____
Signature Date

B. SCL - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the SCL Waiver program as an alternative to ICF/MR/DD is requested ☐; is not requested ☐.

_____ _____
Signature Date

C. MP - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the MP Waiver program as an alternative to ICF/MR/DD or NF is requested ☐; is not requested ☐.

_____ _____
Signature Date

D. MODEL II - This is to certify that I/legal representative have been informed of the Model II Waiver program. Consideration for the Model II Waiver program as an alternative to ICF/MR/DD is requested ☐; is not requested ☐.

_____ _____
Signature Date

F. ABI - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested ☐; is not requested ☐.

_____ _____
Signature Date

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. MEMBER INFORMATION

Name: _____ Medicaid Member ID #: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

Responsible Party/Legal Representative: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

MAP 351
(Rev. 7/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

SECTION I – MEMBER DEMOGRAPHICS

Name *(last, first, middle)*	Date of birth *(mo., day, yr.)* / /	Medicaid Member ID #
Street address	County code / Sex *(check one)* ☐Male ☐Female	Marital status *(check one)* ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed
City, state and zip code	Emergency contact *(name)*	Emergency contact *(phone #)* ( ) -
Member phone number ( ) -	Is member able to read and write ☐Yes ☐No	Member's height Member's weight

SECTION II – MEMBER WAIVER ELIGIBILITY

Type of program applied for *(check one)* ☐ Home and Community Based Waiver ☐ Acquired Brain Injury Waiver ☐ Supports for Community Living Waiver ☐ Michelle P. Waiver ☐ Consumer Directed Option ☐ Blended	Adjudicated ☐ /Nonadjudicated ☐_____ Type of application *(check one)* ☐ Certification ☐ Re-certification ☐ Re-application
Member admitted from *(check one)* ☐Home ☐Hospital ☐Nursing facility ☐ ICF/MR/DD ☐Other_____	Certification period *(enter dates below)* Begin date / / End date / / Certification number:_____
Has member's freedom of choice been explained and verified by a signature on the MAP 350 Form ☐Yes ☐No	Has member been informed of the process to make a complaint ☐Yes ☐No (*see instructions*)

Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number ( ) -

Enter member's primary diagnosis: HCB (ICD-9 code); SCL (DSM code); ABI (ICD-9 and/or DSM)

Enter all diagnoses including DSM or ICD-9 codes: AXIS I: (mental illness) AXIS II: (MR/DD) AXIS III: (Medical)	Is the member diagnosed with one of the following? ☐ Mental Retardation/ IQ= (Date-of-onset / /) ☐ Developmental Disability (Date-of-onset / /) ☐ Mental Illness (Date-of-onset / /) ☐ Brain Injury Cause of Brain Injury: Date of Brain Injury: / / Rancho Scale

SECTION III – ASSESSMENT PROVIDER INFORMATION

Assessment/Reassessment provider name:	Provider number	Provider phone number ( ) -
Street address	City, state and zip code	
Provider contact person		

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

Name *(last, first)*	**Medicaid Member ID #**

SECTION IV SELF ASSESSMENT

***For SCL, MP and ABI waivers only** ***add additional pages as needed**

Community Inclusion (what do you like to do or where would you like to go in the community, where do you go for recreation, do you not get to go somewhere that you would like to)

Relationships (How do you stay in contact with your friends and family, do you need assistance in making or keeping friends, who are your friends)

Rights (do you understand your rights, are any of your rights restricted, do you know what is abuse or neglect)

Dignity and Respect (how are you treated by staff, do you have a place you can go to be with friends or to be alone or have privacy)

Health (who are your doctors ,do you have any health concerns, what medicine do you take, how do they make you feel,)

Lifestyle (do you have a job, do you want to work, do you want to go to school, do you go to the bank, do you have spending money to carry)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

Name *(last, first)*	**Medicaid Member ID #**
SECTION V – ACTIVITIES OF DAILY LIVING	
1) Is member independent with **dressing/undressing** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires total assistance	Comments:
2) Is member independent with **grooming** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues Requires hands-on assistance with ☐ oral care ☐shaving ☐ nail care ☐hair ☐ Requires total assistance	Comments:
3) Is member independent with **bed mobility** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Bed-bound ☐ Required bedrails	Comments:
4) Is member independent with **bathing** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires Peri-Care ☐ Requires total assistance	Comments:
5) Is member independent with **toileting** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Bladder incontinence ☐ Bowel incontinence ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Requires total assistance ☐ Bowel and bladder regimen	Comments:
6) Is member independent with **eating** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires assistance cutting meat or arranging food ☐ Partial/occasional help ☐ Totally fed (by mouth) ☐ Tube feeding (type and tube location)	Comments:

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
MEDICAID WAIVER ASSESSMENT

Name *(last, first)*	**Medicaid Member ID #**
7) Is member independent with **ambulation** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Dependent on device ☐ Requires aid of one person ☐ Requires aid of two people ☐ History of falls (number of falls, and date of last fall)	Comments:
8) Is member independent with **transferring** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Hands-on assistance of one person ☐ Hands-on assistance of two people ☐ Requires mechanical device ☐ Bedfast	Comments:

SECTION VI - INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1) Is member able to prepare **meals** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for meal preparation ☐ Requires supervision or verbal cues ☐ Requires assistance with meal preparation ☐ Requires total meal preparation	Comments:
2) Is member able to **shop** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for shopping to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with shopping ☐ Unable to participate in shopping	Comments:
3) Is member able to perform light **housekeeping** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for light housekeeping duties to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with light housekeeping ☐ Unable to perform any light housekeeping	Comments:
4) Is member able to perform heavy **housework** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for heavy housework to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with heavy housework ☐ Unable to perform any heavy housework	Comments:

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Name (*last, first*)	**Medicaid Member ID #**
5) Is member able to perform **laundry** tasks ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for laundry to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with laundry tasks ☐ Unable to perform any laundry tasks	Comments:
6) Is member able to plan/arrange for pick-up, delivery, or some means of gaining possession of **medication(s)** and take them independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for medication to be obtained and taken correctly ☐ Requires supervision or verbal cues ☐ Requires assistance with obtaining and taking medication correctly ☐ Unable to obtain medication and take correctly	Comments:
7) Is member able to handle **finances** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for someone else to handle finances ☐ Requires supervision or verbal cues ☐ Requires assistance with handling finances ☐ Unable to handle finances	Comments:
8) Is member able to use the **telephone** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Requires adaptive device to use telephone ☐ Requires supervision or verbal cues ☐ Requires assistance when using telephone ☐ Unable to use telephone	Comments:
SECTION VII-NEURO/EMOTIONAL/BEHAVIORAL	
1) Does member exhibit **behavior** problems ☐Yes ☐No *(If yes, check below all that apply and explain the frequency in comments)* ☐ Disruptive behavior ☐ Agitated behavior ☐ Assaultive behavior ☐ Self-injurious behavior ☐ Self-neglecting behavior	Comments: Date of functional analysis: / / and/or Date of behavior support plan: / /

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Name (*last, first*)	**Medicaid Member ID #**
2) Is member **oriented** to person, place, time ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Forgetful ☐ Confused ☐ Unresponsive ☐ Impaired Judgment	Comments:
3) Has member experienced a major change or crisis within the past twelve months ☐Yes ☐No (*If yes, describe*)	Description:
4) Is the member actively participating in social and/or community activities ☐Yes ☐No (*If yes, describe*)	Description:
5) Is the member experiencing any of the following *(For each checked, explain the frequency and details in the comments section)* ☐Difficulty recognizing others ☐Loneliness ☐Sleeping problems ☐Anxiousness ☐Irritability ☐Lack of interest ☐Short-term memory loss ☐Long-term memory loss ☐Hopelessness ☐Suicidal behavior ☐Medication abuse ☐Substance abuse ☐ Alcohol Abuse	Comments:

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Name (*last, first*)	**Medicaid Member ID #:**
6) Cognitive functioning (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands) ☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. ☐ Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions. ☐ Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. ☐ Required considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.	Comments:
7) When Confused (Reported or Observed): ☐ Never ☐ In new or complex situations only ☐ On awakening or at night only ☐ During the day and evening, but not constantly ☐ Constantly ☐ NA (non-responsive)	Comments:
8) When Anxious (Reported or Observed): ☐ None of the time ☐ Less often than daily ☐ Daily, but not constantly ☐ All of the time ☐ NA (non-responsive)	Comments:
9) Depressive Feelings (Reported or Observed): ☐ Depressed mood (e.g., feeling sad, tearful) ☐ Sense of failure or self-reproach ☐ Hopelessness ☐ Recurrent thoughts of death ☐ Thoughts of suicide ☐ None of the above feelings reported or observed	Comments:

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Name (*last, first*)	**Medicaid Member ID #:**
10) Member Behaviors (Reported or Observed): ☐ Indecisiveness, lack of concentration ☐ Diminished interest in most activities ☐ Sleep disturbances ☐ Recent changes in appetite or weight ☐ Agitation ☐ Suicide attempt ☐ None of the above behaviors observed or reported	Comments:
11) Behaviors Demonstrated at Least Once a Week: ☐ Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24-hours, significant memory loss so that supervision is required. ☐ Impaired decision-making: failure to perform usual ADL's, inability to inappropriately stop activities, jeopardizes safety through actions. ☐ Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. ☐ Physical aggression: aggressive or combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects). ☐ Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions). ☐ Delusional, hallucinatory, or paranoid behavior. ☐ None of the above behaviors demonstrated.	Comments:
12) Frequency of Behavior Problems (Reported or Observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.: ☐ Never ☐ Less than once a month ☐ Once a month ☐ Several times each month ☐ Several times a week ☐ At least daily	Comments:

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Name (*last, first*)	**Medicaid Member ID #:**
13) Mental Status: ☐ Oriented ☐ Forgetful ☐ Depressed ☐ Disoriented ☐ Lethargic ☐ Agitated ☐ Other	Comments:
14) Is this member receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? ☐ Yes ☐ No	Comments:
SECTION VIII-CLINICAL INFORMATION	
1) Is member's **vision** adequate *(with or without glasses)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply and comment)* ☐ Difficulty seeing print ☐ Difficulty seeing objects ☐ No useful vision	Comments:
2) Is member's **hearing** adequate *(with or without hearing aid)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply, and comment)* ☐ Difficulty with conversation level ☐ Only hears loud sounds ☐ No useful hearing	Comments:
3) Is member able to **communicate** needs ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Speaks with difficulty but can be understood ☐ Uses sign language and/or gestures/communication device ☐ Inappropriate context ☐ Unable to communicate	Comments:
4) Does member maintain an adequate **diet** ☐Yes ☐No *(If no, check all that apply and comment)* ☐ Uses dietary supplements ☐ Requires special diet (low salt, low fat, etc.) ☐ Refuses to eat ☐ Forgets to eat ☐ Tube feeding required *(Explain the brand, amount, and frequency in the comments section)* ☐ Other dietary considerations *(PICA, Prader-Willie, etc.)*	Comments:

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Name (*last, first*)	**Medicaid Member ID #:**
5) Does member require **respiratory** care and/or equipment ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Oxygen therapy (Liters per minute and delivery device) ☐ Nebulizer (Breathing treatments) ☐ Management of respiratory infection ☐ Nasopharyngeal airway ☐ Tracheostomy care ☐ Aspiration precautions ☐ Suctioning ☐ Pulse oximetry ☐ Ventilator (list settings)	Comments:
6) Does member have history of a **stroke(s)** ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Residual physical injury(ies) ☐ Swallowing impairments ☐ Functional limitations (Number of limbs affected)	Comments:
7) Does member's **skin** require additional, specialized care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Requires additional ointments/lotions ☐ Requires simple dressing changes (i.e. band-aids, occlusive dressings) ☐ Requires complex dressing changes (i.e. sterile dressing) ☐ Wounds requiring "packing" and/or measurements ☐ Contagious skin infections ☐ Ostomy care	Comments:
8) Does member require routine lab work ☐Yes ☐No *(If yes, what type and how often)*	Comments:
9) Does member require specialized genital and/or urinary care ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ Management of reoccurring urinary tract infection ☐ In-dwelling catheter ☐ Bladder irrigation ☐ In and out catheterization	Comments:
10) Does member require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) ☐Yes ☐No *(If yes, explain in the comments section)*	Comments:
11) Does member have total or partial paralysis ☐Yes ☐No *(If yes, list limbs affected and comment)*	Comments:

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Name (*last, first*)	**Medicaid Member ID #:**
12) Does member require assistance with changes in body position ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ To maintain proper body alignment ☐ To manage pain ☐ To prevent further deterioration of muscle/joints/skin	Comments:

13) Does member require 24 hour caregiver ☐Yes ☐No

14) Does member require respite services ☐Yes ☐No *(If yes, how often)*

15) Does the member require intravenous fluids, intravenous medications or intravenous alimentation ☐Yes ☐No *(If yes, check below all that apply and list solution, location, amount, rate, frequency and prescribing physician)*

☐ **Peripheral IV** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	
☐ **Central line** Solution:	Location	Amount/dosage	Rate
Frequency		Prescribing physician	

16) Drug allergies *(list)*	**17)** Other allergies *(list)*

17) Does the member use any medications ☐Yes ☐No *(If yes, list below) *add additional pages if needed*

Name of medication	**Dosage/Frequency/Route**	**Administered by**

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Name (*last, first*)	**Medicaid Member ID #:**

18) Is any of the following adaptive equipment required *(If needs, explain in the comments)*

Dentures	☐Has	☐Needs	☐N/A
Hearing aid	☐Has	☐Needs	☐N/A
Glasses/lenses	☐Has	☐Needs	☐N/A
Hospital bed	☐Has	☐Needs	☐N/A
Bedpan	☐Has	☐Needs	☐N/A
Elevated toilet seat	☐Has	☐Needs	☐N/A
Bedside commode	☐Has	☐Needs	☐N/A
Prosthesis	☐Has	☐Needs	☐N/A
Ambulation aid	☐Has	☐Needs	☐N/A
Tub seat	☐Has	☐Needs	☐N/A
Lift chair	☐Has	☐Needs	☐N/A
Wheelchair	☐Has	☐Needs	☐N/A
Brace	☐Has	☐Needs	☐N/A
Hoyer lift	☐Has	☐Needs	☐N/A

Comments:

19) Please describe in detail any information regarding health, safety and welfare/crisis issues:

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Name ***(last, first)***	**Medicaid Member ID #:**

SECTION IX-ENVIRONMENT INFORMATION

1) Answer the following items relating to the member's physical environment *(Comment if necessary)*

Sound dwelling	☐Yes ☐No	Comments:
Adequate furnishings	☐Yes ☐No	
Indoor plumbing	☐Yes ☐No	
Running water	☐Yes ☐No	
Hot water	☐Yes ☐No	
Adequate heating/cooling	☐Yes ☐No	
Tub/shower	☐Yes ☐No	
Stove	☐Yes ☐No	
Refrigerator	☐Yes ☐No	
Microwave	☐Yes ☐No	
Telephone	☐Yes ☐No	
TV/radio	☐Yes ☐No	
Washer/dryer	☐Yes ☐No	
Adequate lighting	☐Yes ☐No	
Adequate locks	☐Yes ☐No	
Adequate fire escape	☐Yes ☐No	
Smoke alarms	☐Yes ☐No	
Insect/rodent free	☐Yes ☐No	
Accessible	☐Yes ☐No	
Safe environment	☐Yes ☐No	
Trash management	☐Yes ☐No	

2) Provide an inventory of home adaptations **<u>already present</u>** in the member's dwelling. *(Such as wheelchair ramp, tub rails, etc.)*

SECTION X – HOUSEHOLD INFORMATION

1) Does the member live alone ☐Yes ☐No
If yes, does the member receive any assistance from others ☐Yes ☐No *(Explain)*

Comments:

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Name ***(last, first)***			**Medicaid Member ID #:**
2)Household Members *(Fill in household member info below)*			
a) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
b) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

SECTION XI-ADDITIONAL SERVICES

1) Has the member had any hospital, nursing facility or ICF/MR/DD admissions in the past 12 months?
☐Yes ☐No *(If yes, please list below)*

a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

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Name ***(last, first)***	**Medicaid Number**

2) Does the member receive services from other agencies *(Example: Both Waiver and Non-waiver Services.)* ☐Yes ☐No
(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care and traditional Home health services covered by Medicare/Third party insurance)

a-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units
b-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units
c-Service(s) received	Agency/worker name	Phone number ( ) -
Agency address	Frequency	Number of units

SECTION XII-CONSUMER DIRECTED OPTION

Has the member been provided information on Consumer Directed Option (CDO) and their right to choose CDO, traditional or blended services? ☐ Yes ☐ No **If no, give reason:**

Has the member chosen Consumer Direction Option? ☐Yes ☐No If yes, include form MAP 2000

SECTION XIII-SIGNATURES

Person(s) performing assessment or reassessment:

Signature:	Title:	Date / /
Signature:	Title:	Date / /

Verbal Level of Care Confirmation:

Date: / /	Time: am/pm

Assessment/Reassessment forwarded to Support Broker/Case Management provider:

Date Forwarded: / /	Time Forwarded: am/pm
Name of Person Forwarding:	Title of Person Forwarding:

Receipt of assessment/reassessment by Support Broker/case management provider:

Date Received: / /	Time Received: am/pm
Name of Person Logging Receipt:	Title of Person Logging Receipt:

QIO Signature:	Level of Care Date / /	Approval dates From: / / To: / /

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INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

☐ **SCL**
☐ **MP**
☐ **HCB**
☐ **ABI**
☐ **ABI/LTC**

Member Name: _____ Medicaid Member ID #: _____

Case Manager/Support Broker: _____ _____
(Name) (Phone)

Provider Number: _____

☐ Addition of CDO Services Date: _____ Initials: _____

I understand that I have the freedom to choose the Consumer Directed Option for some or all of my waiver services. This has been explained to me and I choose consumer directed services. In making this decision, I understand the following terms of the program:

I understand that I may:

- Train or arrange training for employees necessary for providing care.
- Ask for a change in my Plan of Care (POC)/Support Spending Plan (SSP) if I feel my needs have changed.
- Select a representative to help me with decisions about the CDO.
- Bring whomever I want to all meetings pertaining to the CDO.
- Complain or ask for a hearing if I have problems with my health care.
- Voluntarily dis-enroll from the CDO Program at any time and receive my services through the traditional waiver program.

I understand that I shall:

- Develop a POC/SSP to meet my needs within the Consumer Directed Options (CDO) according to program guidelines and my individual budget.
- Hire, supervise, and when necessary, fire my providers.
- Submit timesheets, paperwork required for my employees.
- Treat my providers and others that work for the CDO program the same way I want to be treated.
- Participate in the development of my POC/SSP and manage my individual budget.
- Complete all the paperwork necessary to participate in the CDO program, and follow all tax and labor laws,
- Be treated with respect and dignity and to have my privacy respected.
- Keep all my scheduled appointments.
- Pay my patient liability as determined by Department for Community Based Services (DCBS), failure to do so will result in termination from CDO.

*For addition of CDO services, attach revised MAP 109 Plan of Care.

Date traditional case management ends and Support Broker begins _____/_____/_____
Date traditional services end and CDO services begin: _____/_____/_____

Kentucky UNBRIDLED SPIRIT

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INITIATION/TERMINATION OF CONSUMER DIRECTED OPTION (CDO)

Member Name: _____ Medicaid Member ID # _____

☐ Representative Designation Date: _____ Initials: _____

I appoint _____ as my representative for the Consumer Directed Option (CDO) Program.

_____
(Address)

_____ **KY**_____ _____
(City) (Zip) (Phone)

Relationship to Consumer: _____

My representative and I understand the following requirements

A CDO representative must:

- Be at least 21 years of age
- Not be paid for this role or for providing any other service to me
- Be responsible for assisting me in managing my care and individual budget
- Participate in training as directed by me and/or my support broker
- Have a strong personal commitment to me and know my preferences
- Have knowledge of me and be willing to learn about resources available in my community
- Be chosen by me

*For voluntary or involuntary termination of CDO service, attach revised MAP 109-Plan of Care.

☐ Voluntary Termination of CDO Services Date: _____Initials: _____

I choose to terminate my services through the Consumer Directed Option and choose to receive my services through the traditional waiver program.

☐ Involuntary Termination of CDO Services
(To be completed by the Support Broker)

Reason for termination of CDO:
☐ Health and Safety Concerns
☐ Exceeding Individual Budget
☐ Inappropriate Utilization of Funds
☐ Other (Describe)

Traditional Provider Agency_____
Traditional Provider Number_____

_____ _____
Consumer/Guardian Signature Date

_____ _____
Representative Signature Date

_____ _____
Case Manager/Support Broker Signature Date

Mayo-Portland Adaptability Inventory-4

Muriel D. Lezak, PhD, ABPP & James F. Malec, PhD, ABPP

Name: _____ Clinic # _____ Date _____

Person reporting (circle one): Single Professional Professional Consensus Person with brain injury Significant other: _____

Below each item, circle the number that best describes the level at which the person being evaluated experiences problems. Mark the greatest level of problem that is appropriate. Problems that interfere rarely with daily or valued activities, that is, less than 5% of the time, should be considered not to interfere. Write comments about specific items at the end of the rating scale.

For Items 1-20, please use the rating scale below.

0	None	**1**	Mild problem but does not interfere with activities; may use assistive device or medication	**2**	Mild problem; interferes with activities 5-24% of the time	**3**	Moderate problem; interferes with activities 25-75% of the time	**4**	Severe problem; interferes with activities more than 75% of the time

Part A. Abilities

1. Mobility: Problems walking or moving; balance problems that interfere with moving about
0 1 2 3 4

2. Use of hands: Impaired strength or coordination in one or both hands
0 1 2 3 4

3. Vision: Problems seeing; double vision; eye, brain, or nerve injuries that interfere with seeing
0 1 2 3 4

4. *Audition: Problems hearing; ringing in the ears
0 1 2 3 4

5. Dizziness: Feeling unsteady, dizzy, light-headed
0 1 2 3 4

6. Motor speech: Abnormal clearness or rate of speech; stuttering
0 1 2 3 4

7A. Verbal communication: Problems expressing or understanding language
0 1 2 3 4

7B. Nonverbal communication: Restricted or unusual gestures or facial expressions; talking too much or not enough; missing nonverbal cues from others
0 1 2 3 4

8. Attention/Concentration: Problems ignoring distractions, shifting attention, keeping more than one thing in mind at a time
0 1 2 3 4

9. Memory: Problems learning and recalling new information
0 1 2 3 4

10. Fund of Information: Problems remembering information learned in school or on the job; difficulty remembering information about self and family from years ago
0 1 2 3 4

11. Novel problem-solving: Problems thinking up solutions or picking the best solution to new problems
0 1 2 3 4

12. Visuospatial abilities: Problems drawing, assembling things, route-finding, being visually aware on both the left and right sides
0 1 2 3 4

Part B. Adiustment

13. Anxiety: Tense, nervous, fearful, phobias, nightmares, flashbacks of stressful events
0 1 2 3 4

14. Depression: Sad, blue, hopeless, poor appetite, poor sleep, worry, self-criticism
0 1 2 3 4

15. Irritability, anger, aggression: Verbal or physical expressions of anger
0 1 2 3 4

16. *Pain and headache: Verbal and nonverbal expressions of pain; activities limited by pain
0 1 2 3 4

17. Fatigue: Feeling tired; lack of energy; tiring easily
0 1 2 3 4

18. Sensitivity to mild symptoms: Focusing on thinking, physical or emotional problems attributed to brain injury; rate only how concern or worry about these symptoms affects current functioning over and above the effects of the symptoms themselves
0 1 2 3 4

19. Inappropriate social interaction: Acting childish, silly, rude, behavior not fitting for time and place
0 1 2 3 4

20. Impaired self-awareness: Lack of recognition of personal limitations and disabilities and how they interfere with everyday activities and work or school
0 1 2 3 4

Use scale at the bottom of the page to rate item #21

21. Family/significant relationships: Interactions with close others; describe stress within the family or those closest to the person with brain injury; "family functioning" means cooperating to accomplish those tasks that need to be done to keep the household running

0	Normal stress within family or other close network of relationships	**1**	Mild stress that does not interfere with family functioning	**2**	Mild stress that interferes with family functioning 5-24% of the time	**3**	Moderate stress that interferes with family functioning 25-75% of the time	**4**	Severe stress that interferes with family functioning more than 75% of the time

Part C. Participation

22. Initiation: Problems getting started on activities without prompting

0 None	**1** Mild problem but does not interfere with activities; may use assistive device or medication	**2** Mild problem; interferes with activities 5-24% of the time	**3** Moderate problem; interferes with activities 25-75% of the time	**4** Severe problem; interferes with activities more than 75% of the time

23. Social contact with friends, work associates, and other people who are not family, significant others, or professionals

0 Normal involvement with others	**1** Mild difficulty in social situations but maintains normal involvement with others	**2** Mildly limited involvement with others (75-95% of normal interaction for age)	**3** Moderately limited involvement with others (25-74% of normal interaction for age)	**4** No or rare involvement with others (less than 25% of normal interaction for age)

24. Leisure and recreational activities

0 Normal participation in leisure activities for age	**1** Mild difficulty in these activities but maintains normal participation	**2** Mildly limited participation (75-95% of normal participation for age)	**3** Moderately limited participation (25-74% of normal participation for age)	**4** No or rare participation (less than 25% of normal participation for age)

25. Self-care: Eating, dressing, bathing, hygiene

0 Independent completion of self-care activities	**1** Mild difficulty, occasional omissions or mildly slowed completion of self-care; may use assistive device or require occasional prompting	**2** Requires a little assistance or supervision from others (5-24% of the time) including frequent prompting	**3** Requires moderate assistance or supervision from others (25-75% of the time)	**4** Requires extensive assistance or supervision from others (more than 75% of the time)

26. Residence: Responsibilities of independent living and homemaking (such as, meal preparation, home repairs and maintenance, personal health maintenance beyond basic hygiene including medication management) but not including managing money (see #29)

0 Independent; living without supervision or concern from others	**1** Living without supervision but others have concerns about safety or managing responsibilities	**2** Requires a little assistance or supervision from others (5-24% of the time)	**3** Requires moderate assistance or supervision from others (25-75% of the time)	**4** Requires extensive assistance or supervision from others (more than 75% of the time)

27. *Transportation

0 Independent in all modes of transportation including independent ability to operate a personal motor vehicle	**1** Independent in all modes of transportation, but others have concerns about safety	**2** Requires a little assistance or supervision from others (5-24% of the time); cannot drive	**3** Requires moderate assistance or supervision from others (25-75% of the time); cannot drive	**4** Requires extensive assistance or supervision from others (more than 75% of the time); cannot drive

28A. *Paid Employment: Rate either item 28A or 28B to reflect the primary desired social role. Do not rate both. Rate 28A if the primary social role is paid employment. If another social role is primary, rate only 28B. For both 28A and 28B, "support" means special help from another person with responsibilities (such as, a job coach or shadow, tutor, helper) or reduced responsibilities. Modifications to the physical environment that facilitate employment are not considered as support.

0 Full-time (more than 30 hrs/wk) without support	**1** Part-time (3 to 30 hrs/ wk) without support	**2** Full-time or part-time with support	**3** Sheltered work	**4** Unemployed; employed less than 3 hours per week

28B. *Other employment: Involved in constructive, role-appropriate activity other than paid employment.
Check only one to indicate primary desired social role: Childrearing/care-giving Homemaker, no childrearing or care-giving Student Volunteer Retired (Check retired only if over age 60; if unemployed, retired as disabled and under age 60, indicate "Unemployed" for item 28A.

0 Full-time (more than 30 hrs/wk) without support; full-time course load for students	**1** Part-time (3 to 30 hrs/ wk) without support	**2** Full-time or part-time with support	**3** Activities in a supervised environment other than a sheltered workshop	**4** Inactive; involved in role-appropriate activities less than 3 hours per week

29. Managing money and finances: Shopping, keeping a check book or other bank account, managing personal income and investments; if independent with small purchases but not able to manage larger personal finances or investments, rate 3 or 4.

0 Independent, manages small purchases and personal finances without supervision or concern from others	**1** Manages money independently but others have concerns about larger financial decisions	**2** Requires a little help or supervision (5-24% of the time) with large finances; independent with small purchases	**3** Requires moderate help or supervision (25-75% of the time) with large finances; some help with small purchases	**4** Requires extensive help or supervision (more than 75% of the time) with large finances; frequent help with small purchases

Part D: Pre-existing and associated conditions. The items below do not contribute to the total score but are used to identify special needs and circumstances. For each rate, pre-injury and post-injury status.

30. Alcohol use: Use of alcoholic beverages.

Pre-injury _____ Post-injury _____

0	No or socially acceptable use	**1**	Occasionally exceeds socially acceptable use but does not interfere with everyday functioning; current problem under treatment or in remission	**2**	Frequent excessive use that occasionally interferes with everyday functioning; possible dependence	**3**	Use or dependence interferes with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

31. Drug use: Use of illegal drugs or abuse of prescription drugs.

Pre-injury _____ Post-injury _____

0	No or occasional use	**1**	Occasional use does not interfere with everyday functioning; current problem under treatment or in remission	**2**	Frequent use that occasionally interferes with everyday functioning; possible dependence	**3**	Use or dependence interferes with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

32. Psychotic Symptoms: Hallucinations, delusions, other persistent severely distorted perceptions of reality.

Pre-injury _____ Post-injury _____

0	None	**1**	Current problem under treatment or in remission; symptoms do not interfere with everyday functioning	**2**	Symptoms occasionally interfere with everyday functioning but no additional evaluation or treatment recommended	**3**	Symptoms interfere with everyday functioning; additional treatment recommended	**4**	Inpatient or residential treatment required

33. Law violations: History before and after injury.

Pre-injury _____ Post-injury _____

0	None or minor traffic violations only	**1**	Conviction on one or two misdemeanors other than minor traffic violations	**2**	History of more than two misdeameanors other than minor traffic violations	**3**	Single felony conviction	**4**	Repeat felony convictions

34. Other condition causing physical impairment: Physical disability due to medical conditions other than brain injury, such as, spinal cord injury, amputation. Use scale below #35.

Pre-injury _____ Post-injury _____

35. Other condition causing cognitive impairment: Cognitive disability due to nonpsychiatric medical conditions other than brain injury, such as, dementia, stroke, developmental disability.

Pre-injury _____ Post-injury _____

0	None	**1**	Mild problem but does <u>not</u> interfere with activities; may use assistive device or medication	**2**	Mild problem; interferes with activities 5-24% of the time	**3**	Moderate problem; interferes with activities 25-75% of the time	**4**	Severe problem; interferes with activities more than 75% of the time

Comments:

Item #

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Scoring Worksheet

Items with an asterisk (4, 16, 27, 28/28A) require rescoring as specified below before Raw Scores are summed and referred to Reference Tables to obtain Standard Scores. Because items 22-24 contribute to both the Adjustment Subscale and the Participation Subscale, the Total Score will be less than the sum of the three subscales.

Abilities Subscale

Rescore item 4. Original score = _____
If original score = 0, new score = 0
If original score = 1, 2, or 3, new score = 1
If original score = 4, new score = 3

A. New score for item 4 = _____
B. Sum of scores for items 1-3 and 5-12 = _____
(use highest score for 7A or 7B)

Sum of A and B = Raw Score for Abilities subscale = _____ (place in Table below)

Adjustment Subscale

Rescore item 16. Original score = _____
If original score = 0, new score = 0
If original score = 1 or 2, new score = 1.
If original score = 3 or 4, new score = 2

C. New score for item 16 = _____
D. Sum of scores for items 13-15 and 17-24 _____

Sum of C and D = Raw Score for Adjustment Subscale _____ (place in Table below)

Participation Subscale

Rescore item 27. Original score = _____
If original score = 0 or 1, new score = 0
If original score = 2 or 3, new score = 1
If original score = 4, new score = 3

Rescore item 28A or 28B. Original score = _____
If original score = 0, new score = 0
If original score = 1 or 2, new score = 1
If original score = 3 or 4, new score = 3

E. New score for item 27 = _____
F. New score for item 28Aor 28B = _____
G. Sum of scores for items 22-24 = _____ (place in Table below)
H. Sum of scores for items 25, 26, 29 = _____

Sum of E through H = Raw Score for Participation Subscale = _____ (place in Table below)

Use Reference Tables to Convert Raw Scores to Standard Scores

	Raw Scores (from worksheet above)	**Standard** (Obtain from appropriate reference Table)
I. Ability Subscale (Items 1-12)	_____	_____
II. Adjustment Subscale (Items 13-24)	_____	_____
III. Participation Subscale (Items 22-29)	_____	_____
IV. Subtotal of Subscale Raw Scores (I-III)	_____	
V. Sum of scores for items 22-24	_____	
VI. Subtract from V. from IV = Total Score	_____	_____

Person Centered Planning: Guiding Principles

Supports for individuals with disabilities will:

- √ Ensure dignity and respect for each person as a valued individual.
- √ Be entitled to the rights, privileges, opportunities, and responsibilities of community membership.
- √ Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life.
- √ Be based on individually determined goals, choices, and priorities.
- √ Be easily accessed and provided regardless of the intensity of individual need.
- √ Be afforded the opportunity to direct the planning, selection, implementation, and evaluation of their services and supports.
- √ Require that funding be flexible and cost effective and make use of natural, generic, and specialized resources.
- √ Be the primary decision makers in their own lives.
- √ Be evaluated based on outcomes for individuals.

The work we do and the way we work will:

- √ Ensure that all persons have dignity and value, and are worthy of respect.
- √ Provide safeguards to ensure personal security, safety, and protection of legal and human rights.
- √ Be coordinated on person-centered and family-centered principles, focusing on individual needs, strengths, and choices.
- √ Support that all people have strengths and abilities and are the primary decision-makers in their lives.
- √ Provide information and supports that promote informed decision-making
- √ Promote partnerships with all stakeholders critical to the success of our efforts.
- √ Be accessible and culturally responsible.
- √ Access informal and generic community resources whenever possible in the most integrated community setting appropriate to the person.
- √ Be based on best practice and utilize state-of-the-art skills and information.
- √ Be directed toward the achievement of interdependence, contribution, and meaningful participation in the community.
- √ Distribute resources in an equitable manner according to individual need and comply with requirements governing public funds administered by the system.

RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

PATIENT INFORMATION

Family Guide to The Rancho Levels of Cognitive Functioning

Cognition refers to a person's thinking and memory skills. Cognitive skills include paying attention, being aware of one's surroundings, organizing, planning, following through on decisions, solving problems, judgement, reasoning, and awareness of problems. Memory skills include the ability to remember things before and after the brain injury. Because of the damage caused by a brain injury, some or all of these skills will be changed.

The Rancho Levels of Cognitive Functioning is an evaluation tool used by the rehabilitation team. The eight levels describe the patterns or stages of recovery typically seen after a brain injury. This helps the team understand and focus on the person's abilities and design an appropriate treatment program. Each person will progress at their own rate, depending on the severity of the brain damage, the location of the injury in the brain and length of time since the brain injury. Some individuals will pass through each of the eight levels, while others may progress to a certain level and fail to change to the next higher level.

It is important to remember that each person is an individual and there are many factors that need to be considered when assigning a level of cognition. There are a range of abilities within each of the levels and your family member may exhibit some or all of the behaviors listed below.

COGNITIVE LEVEL I
NO RESPONSE

A person at this level will:

- not respond to sounds, sights, touch or movement.

COGNITIVE LEVEL II
GENERALIZED RESPONSE

A person at this level will:

- begin to respond to sounds, sights, touch or movement;
- respond slowly, inconsistently, or after a delay;
- responds in the same way to what he hears, sees or feels. Responses may include chewing, sweating, breathing faster, moaning, moving, and/or increasing blood pressure.

COGNITIVE LEVEL III
LOCALIZED RESPONSE

A person at this level will:

- be awake on and off during the day;
- make more movements than before;
- react more specifically to what he sees, hears, or feels. For example, he may turn towards a sound, withdraw from pain, and attempt to watch a person move around the room;
- react slowly and inconsistently;
- begin to recognize family and friends;
- follow some simple directions such as "Look at me" or "squeeze my hand";
- begin to respond inconsistently to simple questions with "yes" and "no" head nods.

What family/friends can do at Cognitive Levels I, II, and III

- Explain to the individual what you are about to do. For example, "I'm going to move your leg."
- Talk in a normal tone of voice.
- Keep comments and questions short and simple. For example, instead of "Can you turn your head

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towards me?", say, "Look at me".
- Tell the person who you are, where he is, why he is in the hospital, and what day it is.
- Limit the number of visitors to 2-3 people at a time.
- Keep the room calm and quiet.
- Bring in favorite belongings and pictures of family members and close friends.
- Allow the person extra time to respond, but don't expect responses to be correct. Sometimes the person may not respond at all.
- Give him rest periods. He will tire easily.
- Engage him in familiar activities, such as listening to his favorite music, talking about the family and friends, reading out loud to him, watching TV, combing his hair, putting on lotion, etc.
- He may understand parts of what you are saying. Therefore, be careful what you say in front of the individual.

COGNITIVE LEVEL IV

CONFUSED AND AGITATED

A person at this level may:

- be very confused and frightened;
- not understand what he feels or what is happening around him;
- overreact to what he sees, hears, or feels by hitting, screaming, using abusive language, or thrashing about. This is because of the confusion;
- be restrained so he doesn't hurt himself;
- be highly focused on his basic needs; ie., eating, relieving pain, going back to bed, going to the bathroom, or going home;
- may not understand that people are trying to help him;
- not pay attention or be able to concentrate for a few seconds;
- have difficulty following directions;
- recognize family/friends some of the time;
- with help, be able to do simple routine activities such as feeding himself, dressing or talking.

What family/friends can do at Cognitive Level IV:

- Tell the person where he is and reassure him that he is safe.
- Bring in family pictures and personal items from home, to make him feel more comfortable.
- Allow him as much movement as is safe.
- Take him for rides in his wheelchair, with permission from nursing.
- Experiment to find familiar activities that are calming to him such as listening to music, eating, etc.
- Do not force him to do things. Instead, listen to what he wants to do and follow his lead, within safety limits.
- Since he often becomes distracted, restless, or agitated, you may need to give him breaks and change activities frequently.
- Keep the room quiet and calm. For example, turn off the TV and radio, don't talk too much and use a calm voice.
- Limit the number of visitors to 2-3 people at a time.

COGNITIVE LEVEL V

CONFUSED AND INAPPROPRIATE

A person at this level may:

- be able to pay attention for only a few minutes;
- be confused and have difficulty making sense of things outside himself;
- not know the date, where he is or why he is in the hospital;
- not be able to start or complete everyday activities, such as brushing his teeth, even when physically able. He may need step-by-step instructions;
- become overloaded and restless when tired or when there are too many people around; have a very poor memory, he will remember past events from before the accident better than his daily routine or information he has been told since the injury;
- try to fill in gaps in memory by making things up; (confabulation)

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- may get stuck on an idea or activity (perseveration) and need help switching to the next part of the activity;
- focus on basic needs such as eating, relieving pain, going back to bed, going to the bathroom, or going home.

What family/friends can do at Cognitive Level V.

- Repeat things as needed. Don't assume that he will remember what you tell him.
- Tell him the day, date, name and location of the hospital, and why he is in the hospital when you first arrive and before you leave.
- Keep comments and questions short and simple.
- Help him organize and get started on an activity.
- Bring in family pictures and personal items from home.
- Limit the number of visitors to 2-3 at a time.
- Give him frequent rest periods when he has problems paying attention.

COGNITIVE LEVEL VI
CONFUSED AND APPROPRIATE

A person at this level may:

- be somewhat confused because of memory and thinking problems, he will remember the main points from a conversation, but forget and confuse the details. For example, he may remember he had visitors in the morning, but forget what they talked about;
- follow a schedule with some assistance, but becomes confused by changes in the routine;
- know the month and year, unless there is a severe memory problem;
- pay attention for about 30 minutes, but has trouble concentrating when it is noisy or when the activity involves many steps. For example, at an intersection, he may be unable to step off the curb, watch for cars, watch the traffic light, walk, and talk at the same time;
- brush his teeth, get dressed, feed himself etc., with help;
- know when he needs to use the bathroom;
- do or say things too fast, without thinking first;
- know that he is hospitalized because of an injury, but will not understand all of the problems he is having;
- be more aware of physical problems than thinking problems;
- associate his problems with being in the hospital and think that he will be fine as soon as he goes home.

What family/friends can do at Cognitive Level VI:

- You will need to repeat things. Discuss things that have happened during the day to help the individual improve his memory.
- He may need help starting and continuing activities.
- Encourage the individual to participate in all therapies. He will not fully understand the extent of his problems and the benefits of therapy.

COGNITIVE LEVEL VII
AUTOMATIC AND APPROPRIATE

A person at this level may:

- follow a set schedule;
- be able to do routine self care without help, if physically able. For example, he can dress or feed himself independently; have problems in new situations and may become frustrated or act without thinking first;
- have problems planning, starting, and following through with activities;
- have trouble paying attention in distracting or stressful situations. For example, family gatherings, work, school, church, or sports events;
- not realize how his thinking and memory problems may affect future plans and goals. Therefore, he may expect to return to his previous lifestyle or work;

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- continue to need supervision because of decreased safety awareness and judgment. He still does not fully understand the impact of his physical or thinking problems;
- think slower in stressful situations;
- be inflexible or rigid, and he may seem stubborn. However, his behaviors are related to his brain injury;
- be able to talk about doing something, but will have problems actually doing it.

COGNITIVE LEVEL VIII
PURPOSEFUL AND APPROPRIATE

A person at this level may:

- realize that he has a problem in his thinking and memory;
- begin to compensate for his problems;
- be more flexible and less rigid in his thinking. For example, he may be able to come up with several solutions to a problem;
- be ready for driving or job training evaluation;
- be able to learn new things at a slower rate;
- still become overloaded with difficult, stressful or emergency situations;
- show poor judgment in new situations and may require assistance;
- need some guidance to make decisions;
- have thinking problems that may not be noticeable to people who did not know the person before the injury.

What family/friends can do at Cognitive Levels VII/VIII

- Treat the person as an adult by providing guidance and assistance in decision making. His opinions should be respected.
- Talk with the individual as an adult. There is no need to try to use simple words or sentences.
- Be careful when joking or using slang, because the individual may misunderstand the meaning. Also, be careful about teasing him.
- Help the individual in familiar activities so he can see some of the problems he has in thinking, problem solving, and memory. Talk to him about these problems without criticizing. Reassure him that the problems are because of the brain injury.
- Strongly encourage the individual to continue with therapy to increase his thinking, memory and physical abilities. He may feel he is completely normal. However, he is still making progress and may possibly benefit from continued treatment.
- Be sure to check with the physician on the individual's restrictions concerning, driving, working, and other activities. Do not just rely on him for information, since he may feel he is ready to go back to his previous lifestyle.
- Discourage him from drinking or using drugs, due to medical complications.
- Encourage him to use note taking as a way to help with his remaining memory problems.
- Encourage him to carry out his self-care as independently as possible.
- Discuss what kinds of situations make him angry and what he can do in these situations.
- Talk with him about his feelings.
- Learning to live with a brain injury can be difficult and it may take a long time for the individual and family to adjust. The social worker and/or psychologist will provide the family/friends with information regarding counseling, resources, and/or support organizations.

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